

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36059

State File No.

FILED NOV 2 - 1953

4953

BIRTH NO.		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4953</u>			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>15 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6504 E. 37th (in office)</u>				STREET ADDRESS (If rural, give location) <u>3605 Fuller</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>WALTER</u> b. (Middle) <u>C.</u> c. (Last) <u>ROOT</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10-14-53</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov. 6, 1884</u>			
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 2 HRS. Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - J.C. Transport Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>			11. BIRTHPLACE (City and State or Foreign Country) <u>Centralia, Kansas</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>Sylvester Root</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Sophia Lee</u>		14. NAME OF HUSBAND OR WIFE <u>Gertrude Mae Root</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>509-01-5350</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Gertrude Root, 3605 Fuller, K.C. MO.</u>				ADDRESS <u></u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Haemorrhage</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS <u>Hypertension Essential.</u> Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>3 3/4</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>1947</u> , 19 <u> </u> , to <u>10-14</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>10/1</u> , 19 <u>53</u> , and that death occurred at <u>9 A</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>Paul A. G. Johnson M.D.</u>				23b. ADDRESS <u>5111 Linden Ave. Keno.</u>		23c. DATE SIGNED <u>10/14/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-16-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>			
DATE REC'D BY LOCAL REG. <u>10-15-53</u>		REGISTRAR'S SIGNATURE <u>Seraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>STINE & McCLURE UND. CO.</u>		ADDRESS <u>K.C. MO.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Paul A. S. Johnson
3011 a Indip. Ave.
Be 7943
In all afternoon

TOD 9:00 AM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Ernest T. Kemmer*.....

Licensed Embalmer No. 463.....
P. O. Address *Kemmer, Ill*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.